Pediatric Specialists OF TULSA

Authorization To Treat Minors

(anyone that may bring your child other than biological parent or legal guardian)

I hereby authorize the following people to bring my child to an appointment in my absence. I authorize the physical examination and any x-ray, laboratory test, immunization(s), minor surgical procedure and treatment by any physician or advanced practice registered nurse licensed by the State of Oklahoma and hospital service that may be rendered to said minor under the general, specific or special consent of the temporary custodian of the minor; whether such diagnosis is rendered at the office of the physician or at a hospital licensed by the State of Oklahoma. I authorize the physician to call in any necessary consultants in his/their discretion.

Name:_____ Phone:_____

Relationship to Patient:_____

Name:_____ Phone:_____

Relationship to Patient:_____

Name:_____ Phone:_____

Relationship to Patient:_____

Name:_____ Phone:_____

Relationship to Patient:_____

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and said physician is to exercise their best judgment as to the requirements of such diagnosis, medical or surgical procedure.

***This consent shall remain in effect until the _____day of _____, 20___, unless sooner revoked in writing, delivered to said physician or said persons entrusted with the custody, care and control of said child.**

Patient's Name:_____ Date of Birth:_____

Parent/Legal Guardian:_____ Date:_____

Relationship to Patient:_____

Witness:_____